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No. 00-

IN THE

Supreme Court of the United States

WAL-MART STORES, INCORPORATED ASSOCIATES' HEALTH AND WELFARE PLAN; AND ADMINISTRATIVE COMMITTEE, ADMINISTRATOR OF THE PLAN,

Petitioners,

v.

DENISE WELLS,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether federal common law – here, the common fund doctrine – overrides the clear language of an ERISA plan provision requiring a participant to reimburse the plan for all medical benefits paid if he or she recovers those benefits from a third party unless the plan expressly states that the common law doctrine does not apply.

PARTIES TO THE PROCEEDING

All parties to the proceeding are listed in the caption of the case. Wal-Mart Stores, Inc. does not have a parent company; nor does any publicly held company own 10% or more of Wal-Mart's stock. Wal-Mart currently owns more than 60% of Wal-Mart de Mexico, S.A. de C.V., a separately traded stock on BOLSA, the Mexican stock exchange. See Sup. Ct. R. 29.6.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
PARTIES TO THE PROCEEDING	ii
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	1
JURISDICTION	2
STATUTE INVOLVED	2
INTRODUCTION	2
STATEMENT OF THE CASE	5
REASONS FOR GRANTING THE PETITION	8
I. THE SEVENTH CIRCUIT'S DECISION CREATES A CONFLICT AMONG THE COURTS OF APPEALS	10
II. THE QUESTION WHETHER COMMON LAW DOCTRINES OVERRIDE CLEAR PROVISIONS OF AN ERISA PLAN IS IMPORTANT AND RECURRING	16
III. THE SEVENTH CIRCUIT ERRED WHEN IT USED COMMON LAW PRINCIPLES TO OVERRIDE THE EXPRESS TERMS OF AN ERISA PLAN	19
CONCLUSION	20

TABLE OF AUTHORITIES

CASES Page

Alessi v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) 9, 19
Barnes v. *Independent Auto. Dealers Ass'n*, 64 F.3d 1389 (9th Cir. 1995) 13
Bollman Hat Co. v. *Root*, 112 F.3d 113 (3rd Cir. 1997) 8, 11
Cagle v. *Bruner*, 112 F.3d 1510 (11th Cir. 1997) .. 13
Collins v. *American Cast Iron Pipe Co.*, 105 F.3d 1368 (11th Cir. 1997) 18
Curtiss-Wright Corp. v. *Schoonejongen*, 514 U.S. 73 (1995) 4, 9, 18
FMC Corp. v. *Holliday*, 498 U.S. 52 (1990) 16
Firestone Tire & Rubber Co. v. *Bruch*, 489 U.S. 101 (1989) 14
Fort Halifax Packing Co. v. *Coyne*, 482 U.S. 1 (1987) 4, 8, 16, 17, 18
Health Cost Controls v. *Isbell*, 139 F.3d 1070 (6th Cir. 1997) 11, 13
Ingersoll-Rand Co. v. *McClendon*, 498 U.S. 133 (1990) 3, 16, 17, 18
Lockheed Corp. v. *Spink*, 517 U.S. 882 (1996) 9
Marshall v. *Employer Health Ins. Co.*, Nos. 96-6063, 96-6112, 1997 WL 809997 (6th Cir. Dec. 30, 1997) 11
Metropolitan Life Ins. Co. v. *Massachusetts*, 471 U.S. 724 (1985) 8
Pilot Life Ins. Co. v. *Dedeaux*, 481 U.S. 41 (1987) 9
Provident Life & Accident Ins. Co. v. *Waller*, 906 F.2d 985 (4th Cir. 1990) 18
Ryan v. *Federal Express Corp.*, 78 F.3d 123 (3rd Cir. 1996) 11
Shaw v. *Delta Airlines, Inc.*, 463 U.S. 85 (1983) 18

TABLE OF AUTHORITIES – continued

Page

Singer v. *Black & Decker Corp.*, 964 F.2d 1449 (4th Cir. 1992) 19

Trujillo v. *Cyprus Amax Minerals Ret. Plan Comm.*, 203 F.3d 733 (10th Cir. 2000) 10

United McGill Corp. v. *Stinnet*, 154 F.3d 168 (4th Cir. 1998) 8, 11, 13

Wal-Mart Stores, Inc. Assocs.' Health and Welfare Plan v. *Scott*, 27 F. Supp. 2d 1166 (W.D. Ark. 1998) 15

Walker v. *Wal-Mart Stores, Inc.*, 159 F.3d 938 (5th Cir. 1998) 6, 8, 11, 15

Waller v. *Hormel Foods Corp.*, 120 F.3d 138 (8th Cir. 1997) 14

Ward v. *Wal-Mart Stores, Inc. Assocs.' Health and Welfare Plan*, Nos. 98-1285, 98-1346, 1999 WL 801532 (6th Cir. Sept. 30, 1999) ... 11, 13, 15

STATUTES

29 U.S.C. §§ 1001 *et seq.* 2

§ 1132(a)(3) 2

§ 1141(a) 16

OTHER AUTHORITY

1 Dan B. Dobbs, *Dobbs on the Law of Remedies* (2d ed. 1993) 3

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Petitioners,

v.

DENISE WELLS,

Respondent.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners, Wal-Mart Stores, Inc. Associates' Health and Welfare Plan (the "Plan") and the Administrative Committee of the Plan, respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App. 1a-9a) was entered on May 17, 2000, and is reported at 213 F.3d 398 (7th Cir. 2000). The order denying the petition for rehearing and rehearing *en banc* (App. 25a) was entered on June 14, 2000, and is not reported. The opinion of the United States District Court for the Northern District of Indiana (App. 10a-24a) was entered on March 26, 1999, and is not reported.

JURISDICTION

The court of appeals entered its decision and judgment on May 17, 2000. Petitioners timely filed a petition for rehearing and a suggestion for rehearing *en banc* on May 31, 2000, and rehearing was denied on June 14, 2000. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTE INVOLVED

The statute involved in this case is the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* Petitioners invoked section 502(a)(3), 29 U.S.C. § 1132(a)(3), to enforce the terms of an ERISA plan:

> (a) Persons empowered to bring a civil action
>
> A civil action may may be brought –
>
> . . . .
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan . . . .

INTRODUCTION

In this case, the court of appeals held that federal common law – here, the common fund doctrine – overrides an ERISA plan provision requiring a participant to reimburse the plan for all medical benefits paid if he or she recovers those benefits from a third party. Applying the common fund doctrine, the court allowed the participant to deduct from the required

amount of reimbursement a portion of the attorneys' fees incurred in her action against the third party.[1]

This decision conflicts with decisions of the courts of appeals for the Third, Fourth, Fifth, Sixth and Tenth Circuits, holding that similar or identical plan language must be enforced as written and therefore requiring participants who recover benefits from third parties to reimburse their plans in full without any reduction for attorneys' fees. In this case, as the court of appeals explained, "[t]he plan documents entitle the plan to reimbursement of 100 percent of any benefits paid to a participant to the extent of 'any payment . . . by any person or persons considered responsible for the condition giving rise to the medical expense or by their insurers.'" App. 2a. Despite this clear language, the court of appeals refused "[t]o read the Wal-Mart plan literally" and applied the common fund doctrine to reduce the Plan's right to reimbursement by a proportionate amount of attorneys' fees. The other courts of appeals cited above would have applied this language as written and ordered full reimbursement of the Plan; indeed, two of these courts have done so in cases involving the Wal-Mart Plan.

The resolution of this conflict among the courts of appeals is critically important for the fair, just and effective administration of ERISA plans. This Court has often recognized that the uniform interpretation of ERISA is vital to the achievement of its purposes. See, *e.g.*, *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990) (explaining that ERISA's preemption provision is "intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law . . . to minimize the administrative and financial burden of complying with conflicting directives

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[1] Where a lawyer hired by one party creates a fund in which others are entitled to share, those other beneficiaries may be required to pay some attorneys' fees under the common fund doctrine. *See* 1 Dan B. Dobbs, *Dobbs on the Law of Remedies* § 3.10(2) (2d ed. 1993).

among States or between States and the Federal Government"). That concern is particularly apropos where, as here, a national employer is attempting to administer an ERISA plan whose provisions now have one meaning and effect for its employees in some states and regions and a different meaning and effect for employees in others. Such an outcome is fundamentally unfair to a plan's participants and beneficiaries. The conflict by itself creates significant uncertainty and administrative burdens for employers. The holding, which would require plan sponsors to foreclose *by name* all common law doctrines they did not wish to apply, exacerbates these harms. These consequences might well have a negative effect on the substantive benefits provided by ERISA plans. See *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 10 (1987) ("[t]he employer therefore was required to accommodate conflicting regulatory schemes in devising and operating a system for processing claims and paying benefits – precisely the burden that ERISA pre-emption was intended to avoid"); *id.* ("[s]uch a situation would produce considerable inefficiencies, which the employer might choose to offset by lowering benefit levels").

This question is not only important, it is also recurring, as the substantial number of cases addressing the issue demonstrates. Many, if not most, ERISA plans contain reimbursement provisions. The question whether these provisions should be enforced as written or whether common law doctrines, such as the common fund doctrine, are presumed to have continuing application and to override a plan's reimbursement requirement will arise continuously until this Court resolves the conflict among the courts of appeals.

Finally, the decision below is wrong. Under ERISA, employers are not required to provide any particular benefits, and no provision of ERISA establishes substantive requirements for welfare plans, such as the one at issue. See *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 78 (1995). ERISA protects only those benefits provided in the plan; and,

in interpreting a plan, federal courts are to resort to federal common law only where necessary to fill in gaps in the plan or otherwise effectuate ERISA's statutory scheme. Where, as here, an ERISA plan provides for full reimbursement, there is neither a gap to fill nor a legitimate ERISA purpose served by the application of the common fund doctrine specifically or federal common law generally. To the contrary, fulfillment of ERISA's purposes requires enforcement of ERISA plans as written.

This Court should grant certiorari to resolve the conflict among the courts of appeals on this important and recurring question of federal law that was wrongly decided by the court below.

STATEMENT OF THE CASE

1. Wal-Mart Stores, Inc. has established an ERISA welfare plan for its employees: the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan (the "Plan"). Petitioner Administrative Committee (the "Committee") oversees and administers the Plan. Respondent Denise Wells is a Wal-Mart employee and Plan participant. The Plan provides that:

> [t]he PLAN shall have the right to reduce benefits otherwise payable by the PLAN or recover benefits previously paid by the PLAN to the extent of . . . [a]ny payment resulting from a judgment or settlement, or other payment or payments, made or to be made by any person or persons considered responsible for the condition giving rise to the medical expense or by their insurers . . . . [App. 28a.]

2. In 1993, Wells was injured in an automobile accident. The Plan paid $10,982.61 in medical benefits on her behalf. Subsequently, in a civil suit, Wells obtained a $75,000 settlement from the insurer of the driver of the other car involved in the accident. Wells requested that the Committee reduce the Plan's reimbursement by a *pro rata* portion of her attor-

neys' fees. The Committee considered Wells' request, but ultimately decided that the Plan required full reimbursement without reduction for attorneys' fees. Nevertheless, Wells refused to reimburse the Plan.[2]

3. The Plan and its Administrative Committee brought suit in the United States District Court for the Northern District of Indiana, seeking reimbursement and an injunction prohibiting Wells from violating the terms of the Plan by instructing or permitting her lawyer to withhold the $10,982.61 check. The district court granted the plaintiffs' motion for summary judgment and held that the Committee acted within its discretion when it determined that the Plan was entitled to full reimbursement. App. 23a-24a.

Wells invoked two common law doctrines to support her argument that she should be allowed to reduce the amount reimbursed to the Plan by a *pro rata* share of her attorneys' fees: the "make-whole" doctrine (an insurance doctrine that operates to deny the enforcement of subrogation rights until the injured party has been fully compensated for all losses) and the "common fund" doctrine (which permits a party that increases the value of a fund in which others have an interest to recover from the others a reasonable proportion of the litigation expenses). After an exhaustive discussion of Seventh Circuit precedent and an examination of the specific language of the Plan, the district court held that "federal common law [did] not apply," and that the Administrative Committee's decision to decline Wells' request for a *pro rata* reduction "was not arbitrary and capricious." App. 17a-23a. Accordingly, Wells was required to reimburse the Plan in full.

In so doing, the District Court also found it significant that in *Walker* v. *Wal-Mart Stores, Inc.*, 159 F.3d 938, 939 (5th

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[2] Wells' attorney currently has a check for $10,982.61, payable to the attorney, Wells, her husband (who was also involved in the accident), and "Wal-Mart as subrogee of Denise Wells." App. 2a. The attorney has refused to endorse the check over to the Plan.

Cir. 1998), the Fifth Circuit had addressed the precise Plan provisions at issue and concluded that the Plan language requiring full reimbursement was unambiguous, and that the Administrative Committee's interpretation of that language was entitled to deferential arbitrary and capricious review. App. 20a.

4. The Seventh Circuit reversed. The court held that, even though "the plan documents entitle the plan to reimbursement of 100 percent of any benefits paid to the participant" as the result of a favorable settlement or judgment, Wells was entitled to deduct a *pro rata* portion of her attorneys' fees from the amount she was required to reimburse the Plan. App. 2a, 4a-7a.

The court repeatedly acknowledged that the provision on its face required full reimbursement. See App. 2a ("[t]he plan documents entitle the plan to reimbursement of 100 percent of any benefits paid to a participant"); *id.* at 4a ("[t]he language from the plan document . . . seems clear, and clearly to favor the plan's claim"); *id.* at 5a (recognizing that the Plan requires the result sought by the Committee if it is read "literally"). Nevertheless, the court reasoned that "a background of common-sense understandings and legal principles . . . operate as default rules to govern in the absence of a clear expression of the parties' intent that they not govern." *Id.* Because the Plan did not "expressly repudiate common-fund principles" or otherwise specifically address the issue of shared attorneys' fees, the court would "interpolate those principles to avoid wreaking unintended consequences." *Id.* at 6a.

In electing to create a default rule incorporating common fund principles, the court emphasized policy considerations: "[t]o read the Wal-Mart plan literally would allow the plan to free ride on the efforts of the plan participant's attorney, contrary to the equitable concept of 'common fund' . . . . It would also gratuitously deter the exercise of the tort rights of plan participants." App. 5a. The court also observed that in theory the Plan's interpretation of the reimbursement

provision could leave a Plan participant "worse off" than if she had not sued, in the event that the recovery from a third party was less than the amount of benefits paid out by the fund. *Id.* at 5a-6a.

The court sought to distinguish two "superficially" conflicting cases, *United McGill Corp.* v. *Stinnet*, 154 F.3d 168, 172-73 (4th Cir. 1998), and *Bollman Hat Co.* v. *Root*, 112 F.3d 113, 116-18 (3rd Cir. 1997). It stated that while those cases "refuse to invalidate a plan provision interpreted to bar the application of common-fund principles; we pose the issue as one not of validity but of sound application of principles of contract interpretation." App. 6a. The court recognized that another case, *Walker* v. *Wal-Mart Stores, Inc.*, 159 F.3d 938 (5th Cir. 1998), was "[m]ore problematic," (App. 6a), though distinguishable because it "upheld a literal reading of identical language – but did so as a matter of deference to the interpretation by the plan's administrator." *Id.* The court found that the Plan language here did not confer discretion upon the Plan administrator. *Id.* at 7a.[3]

REASONS FOR GRANTING THE PETITION

ERISA "comprehensively regulates employee pension and welfare plans." *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 732 (1985). Indeed, ERISA broadly preempts state regulation of ERISA plans so that ERISA plans are subject only to a unified federal regime. *Fort Halifax*, 482 U.S. at 9. However, "[n]othing in ERISA requires employers to establish employee benefit plans . . . [n]or does ERISA mandate what kind of benefit employers must provide if they

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[3] The court further concluded that a 1996 amendment to the Plan that specified that the Plan would not pay any part of a participant's attorneys' fees did not apply in Wells' case because she had received her benefits well before the date of the amendment. App. 6a. Petitioners do not seek review of the court of appeals' decision that the 1996 plan amendment is not retroactive.

choose to have such a plan." *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 887 (1996). See also *Curtiss-Wright Corp.*, 514 U.S. at 78.[4] The questions whether benefits will be provided and, if so, what kind of benefits they will be, are left to "the private parties creating the plan." *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981). Where there are gaps in the comprehensive statutory scheme created by ERISA, Congress expected that "a federal common law of rights and obligations under ERISA-regulated plans would develop" to fill those gaps. *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 56 (1987).

In this case, the court of appeals held that despite its "clear" and "literal[]" language, the Plan's literal meaning was overcome by "a background of common-sense understandings and legal principles" – here, the federal common law doctrine of the common fund – and thus limited the Plan's right of reimbursement by application of the common fund doctrine. App. 5a. There is, however, no gap for federal common law to fill where, as here, the language of an ERISA plan is unambiguous.

The court of appeals' decision exacerbates an already wide conflict among the courts of appeals concerning when common law doctrines, such as the common fund doctrine, apply to ERISA plans. The conflict, by itself, undermines ERISA's overriding purposes of ensuring uniformity and providing plan sponsors and participants with clear rules. The holding also contravenes ERISA's requirement that private parties are to decide the nature and scope of the benefits provided by an ERISA plan, creating damaging uncertainty in the interpretation and administration of ERISA plans. We turn to an elaboration of these points.

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[4] Instead of creating substantive rules for welfare plans, ERISA seeks to ensure that "employees will not be left empty-handed once employers have guaranteed them certain benefits." *Lockheed Corp.*, 517 U.S. at 887.

I. THE SEVENTH CIRCUIT'S DECISION CREATES A CONFLICT AMONG THE COURTS OF APPEALS.

A. The Seventh Circuit's decision in this case conflicts with the decisions of other courts of appeals which hold that the same or strikingly similar plan language requiring reimbursement of benefits means what it says and must be enforced accordingly. The Seventh Circuit correctly found that the Plan language – "[t]he Plan shall have the right to . . . recover benefits previously paid by the PLAN to the extent of . . . [a]ny payment resulting from a judgment or settlement, or other payment or payments, made or to be made by any person or persons considered responsible for the condition giving rise to the medical expense or by their insurers," App. 28a – was clear. Indeed, it observed, *inter alia*, that the reimbursement provision by its terms "entitle[s] the plan to reimbursement of 100 percent." *Id.* at 2a. See also *id.* at 4a, 5a (quoted *supra* at 7). Despite this language, the court held that the common fund doctrine, a federal common law principle, applied and that it precluded the Plan from obtaining full reimbursement and required the Plan to accept a *pro rata* reduction for attorneys' fees. In the court's view, the common fund doctrine applied because the Plan language, although clear, did not explicitly "repudiate common-fund principles." *Id.* at 6a.

This holding stands in direct conflict with decisions of the Third, Fourth, Fifth, Sixth, and Tenth Circuits, holding that identical or similar plan provisions that require reimbursement of the amount of benefits paid must be enforced as written. Compare App. 6a with *Trujillo* v. *Cyprus Amax Minerals Ret. Plan Comm.*, 203 F.3d 733, 736 (10th Cir. 2000) (reducing disability retirement benefits to a plan participant without regard to attorneys' fees expended by the participant in obtaining worker's compensation benefits where the plan provided that "[t]he Disability Retirement Benefits payable to any Member shall be reduced by the amount of any worker's

compensation benefits . . . payable to him with respect to his disability"); *Walker*, 159 F.3d at 940 (construing the exact plan language at issue in the instant case to require reimbursement of "100% recovery (all) of the funds received by the plaintiff in the settlement, up to the full amount of the benefits paid" and not allowing any reduction for attorneys' fees); *United McGill*, 154 F.3d at 170, 173 (allowing no reduction of reimbursement for attorneys' fees where the plan required a refund to the plan of "'the amount of benefits . . . paid'") (emphasis in original omitted); *Bollman Hat Co.* v. *Root*, 112 F.3d 113, 114 (3rd Cir. 1997) (allowing no reduction where the plan provided subrogation "to the extent of such payment" and required the plan participant to agree "to reimburse the Plan for any [benefit] payments made . . . out of *any* monies recovered" from a third party); *Health Cost Controls* v. *Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997) (enforcing as written the terms of a provision characterized by the court as expressly requiring "full reimbursement of the Plan for medical benefits when the beneficiary recovers sufficient damages from a third party tortfeasor"); *Ryan* v. *Federal Express Corp.*, 78 F.3d 123, 124 (3rd Cir. 1996) (allowing no reduction where the plan provided a right "to be reimbursed by the Covered Participant . . . *100% of the amount of covered benefits paid*"); *Ward* v. *Wal-Mart Stores, Inc. Assocs.' Health and Welfare Plan*, Nos. 98-1285, 98-1346, 1999 WL 801532, at *4 (6th Cir. Sept. 30, 1999) (unpublished opinion) (construing the exact plan language at issue in this case to require "full reimbursement . . . without a deduction for attorneys' fees expended to obtain a settlement"); *Marshall* v. *Employer Health Ins. Co.*, Nos. 96-6063, 96-6112, 1997 WL 809997 (6th Cir. Dec. 30, 1997) (per curiam) (unpublished opinion). In each of these cases, the court considered the same policy arguments and common law principles relied on by the Seventh Circuit here; concluded that, under ERISA, it was required to apply the language of the plan; and refused to reduce the reimbursement due the

plan by a percentage of the litigation expenses incurred by the plan participant.

The Seventh Circuit did not discuss most of these conflicting cases, but attempted unsuccessfully to distinguish two of them as follows. The court claimed that *United McGill* and *Bollman Hat* were only "superficially in conflict" with this case, because those courts "refuse[d] to invalidate a plan provision interpreted to bar the application of common-fund principles," while the issue in the instant case was "one not of validity but of sound application of principles of contract law." App. 6a. Expressed more plainly, the court of appeals said that the other courts accepted the clear language of the plan provisions requiring reimbursement, but that it chose to look beyond the clear language of the Plan at issue here and interpret the Plan in light of the common law, specifically the common fund doctrine. This does not distinguish these cases from the instant case, but rather confirms the existence of a conflict: a plan provision is either enforceable according to its terms, or it is not. The other courts of appeals cited above applied the clear language of the plan provisions at issue, while the court of appeals here recognized that the Plan language had a clear meaning, see *supra* at 7, and nonetheless refused to accept that literal meaning and instead imported common law principles. Far from distinguishing the cited cases, the court of appeals has merely begged the question that now divides the Circuits.

Put differently, the Seventh Circuit's central premise is that common law principles "operate as default rules" that will trump conflicting plan language unless expressly excluded. App. 5a. Under that reasoning, common fund principles negate plan language that requires "100 percent" reimbursement, *id.* at 2a, because the Plan does not "expressly repudiate" those principles. *Id.* at 6a. This approach cannot be reconciled with the decisions from other circuits that have addressed identical or indistinguishable plan language and reached the opposite conclusion. The "default" rule in these

cases is that the clear language of the plan provisions governs. For example, in *Ward*, the Sixth Circuit considered the precise language at issue here and concluded that "when a plan is clear and unambiguous, we cannot apply a common-law rule of interpretation but, inste[a]d must give the plain language of the plan its natural meaning." 1999 WL 801532, at *4. *Accord Walker*, 159 F.3d at 940 ("[t]he Plan's unambiguous language does not include a provision for reduction of its subrogation lien for payment of attorneys' fees or costs"); *United McGill*, 154 F.3d at 173 ("[w]here, as here, the language of the plan does not qualify the right to reimbursement by reference to the cost associated with recovery, we are bound to enforce the contractual provisions as drafted"); *Isbell*, 139 F.3d at 1072 ("[a] primary purpose of ERISA is to ensure the integrity and primacy of written plans. Thus, the plain language of an ERISA plan should be given its literal and natural meaning") (citations omitted).

While the court of appeals' decision conflicts with those of the Third, Fourth, Fifth, Sixth, and Tenth Circuits, the Seventh Circuit is not entirely alone. The Ninth and Eleventh Circuits – when faced with similar conflicts between the language of an ERISA plan provision and a principle of common law – appear to have taken the position that common law principles govern unless they are explicitly disclaimed. Specifically, where the question is whether the federal common law doctrine denominated the "make-whole" doctrine overrides plan provisions requiring full reimbursement, two courts of appeals have held that the make-whole doctrine applies unless the plan expressly states that it does not. See *Cagle* v. *Bruner*, 112 F.3d 1510, 1521 (11th Cir. 1997) (adopting the make-whole rule as a "default" rule in spite of a subrogation provision that gives an ERISA fund "the right to be reimbursed" for "the amount of medical expense paid by the Fund"); *Barnes* v. *Independent Auto. Dealers Ass'n*, 64 F.3d 1389, 1393 (9th Cir. 1995) (adopting the make-whole rule in the absence of an express disavowal despite a plan

provision subrogating the plan "*to all rights of recovery to the extent of its payment*").[5] *Cagle* and *Barnes*, like *Wells* and in conflict with the cases cited *supra* at 10-11, hold that a common law doctrine may be applied to override the clear language of an ERISA plan unless the plan states expressly that the doctrine does not apply. These rulings merely reinforce the profound need to decide how to interpret ERISA plans in light of common law doctrines not in accord with the language of the plan.

B. In addition to the conflict just described, there is also a conflict among the courts of appeals on the question whether the arbitrary and capricious standard of review applies to the Wal-Mart Plan's interpretation of its reimbursement clause. The Plan administrator determined that the language of the Plan did not permit anything less than full reimbursement, and it is well established that this interpretation of the Plan is entitled to deference so long as the Plan gives "the administrator or fiduciary *discretionary authority* to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 115 (1989) (emphasis added). In fact, the Plan gives its administrator the broadest possible discretion:

> The PLAN herein expressly gives the ADMINISTRATIVE COMMITTEE discretionary authority to resolve *all questions concerning the administration, interpretation or application of the PLAN*, including, *without*

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[5] Similarly, in *Waller* v. *Hormel Foods Corp.*, 120 F.3d 138 (8th Cir. 1997), the Eighth Circuit considered a subrogation provision that the court understood to allow the plan to recover "up to the amount of medical benefits the Plan has paid." *Id.* at 140. Because the plan did not specifically address the *amount* that the plan could recover or the question of attorneys' fees, the court refused to require the participant fully to reimburse the plan and instead applied the common fund doctrine and reduced the plan's recovery by the amount of a reasonable attorneys' fee. *See id.* at 141 ("the Plan's subrogation clause contains no provision regarding attorneys' fees").

> *limitation*, discretionary authority to determine eligibility for benefits or to construe the terms of the PLAN in conducting the review of the appeal. [App. 31a (emphasis added).]

Despite this language, the Seventh Circuit applied a *de novo* standard of review, saying that the provision requiring deference applies only to "benefits determination." App. 7a. This is plainly wrong as the language applies to "all questions concerning . . . interpretation . . . of the Plan, including, without limitation . . . benefits." Due to the national coverage of the Wal-Mart Plan, that interpretive decision, in fact, conflicts with the decisions of other courts of appeals construing this precise plan. See *Ward*, 1999 WL 801532, at *2 (applying arbitrary and capricious review because the parties agreed that the Plan language gives discretion to the Administrative Committee); *Walker*, 159 F.3d at 939 ("[t]his provision clearly vested the Administrative Committee with the discretionary authority to interpret the terms of the Plan, therefore, the proper standard of review in this case is for abuse of discretion"). See also *Wal-Mart Stores, Inc. Assocs.' Health and Welfare Plan* v. *Scott*, 27 F. Supp. 2d 1166, 1172 (W.D. Ark. 1998) (because "it is undisputed that the plan gives the administrator 'discretionary authority,'" the court's review is "limited to the question of whether the administrator abused his discretion in deciding that the Plan's provisions call for full reimbursement with no reduction for attorneys' fees and costs").

* * * *

The critical point for purposes of this petition is that, whatever standard of review applies, there is a conflict among the courts of appeals on the question whether a common law doctrine, such as the common fund doctrine, can override the clear meaning of an ERISA plan provision requiring full reimbursement of the plan after a participant receives compensation from a third party. Whether a plan interpretation of the language at issue or similar language is

reviewed *de novo*, as in *Ryan*, *Bollman Hat*, *Isbell*, and the instant case, or to determine whether it is arbitrary or capricious, as in *Ward*, *Walker*, *Scott*, and *Trujillo*, five Circuits would hold that such language provides for full reimbursement and that common law doctrines cannot override that clear language. Two other courts of appeals apparently would hold that the common law doctrine applies unless its application is expressly excluded. The Seventh Circuit's decision thus broadens an already mature conflict on the question presented, and therefore this Court's review of this case is warranted.

II. THE QUESTION WHETHER COMMON LAW DOCTRINES OVERRIDE CLEAR PROVISIONS OF AN ERISA PLAN IS IMPORTANT AND RECURRING.

The extant conflict among the courts of appeals contravenes one of the primary purposes of ERISA – the establishment of a uniform and settled set of rules governing the administration of ERISA plans. This purpose is most clearly manifested in ERISA's broad preemption of all state laws related to ERISA plans. See ERISA section 514(a), 29 U.S.C. § 1141(a). Congress preempted state law in order to ensure "that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *McClendon*, 498 U.S. at 142; *accord Fort Halifax*, 482 U.S. at 11 (recognizing that Congress included the preemption clause to "afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations"); *FMC Corp.* v. *Holliday*, 498 U.S. 52, 60-61 (1996) (holding that ERISA preempts state insurance laws concerning an ERISA plan's subrogation rights).

A continuing conflict among the courts of appeals on an important question of ERISA plan administration undermines these statutory goals just as the application of conflicting state

laws would. Employers cannot enjoy "the advantages of a uniform set of administrative procedures," *Fort Halifax*, 482 U.S. at 11, when the courts of appeals are divided on the issue of whether it is appropriate to use common law equitable principles to alter the meaning or effect of an express provision of an ERISA plan. This point is effectively illustrated by this case. Wal-Mart's Plan is national in scope, and its provisions should have the same meaning in Pennsylvania and Virginia as they do in Indiana or Illinois. As a result of the conflict among the courts of appeals reflected in the decision below, however, Wal-Mart Plan participants have differing rights and obligations depending upon the location of their workplace. This creates unnecessary and costly difficulties for Plan administrators, and inconsistent results resulting in fundamental unfairness to participants. "[D]ifferent substantive standards applicable to the same employer conduct[] requir[e] the tailoring of plans and employer conduct, to the peculiarities of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement." *McClendon*, 498 U.S. at 142.

The continuing conflict also generates substantial uncertainty for ERISA plan administrators. Administrators do not know whether the Seventh Circuit's view or that of the other courts of appeals taking conflicting views will prevail in the jurisdictions of the courts of appeals yet to decide this question. Moreover, for an ERISA plan with national coverage, it may be unclear which jurisdiction's law will govern the reimbursement claim of a particular participant. Finally, the Seventh Circuit's rule appears to require a plan to *name* any common law doctrine whose application it wishes to exclude. There are myriad such doctrines, far too many for a plan to be certain it has excluded every one, and the requirement that a plan must attempt to do so is absurd. A plan should be able to say in clear language what it means and know that the courts will enforce those provisions as written.

The question presented is not only important, it is also recurring. Virtually all ERISA welfare plans have reimbursement provisions. Further, the question whether a common law doctrine can override a clear plan provision arises not only in cases involving the common fund doctrine, but also is central in cases involving reimbursement when a participant receives workers' compensation or uninsured motorist benefits and in cases invoking the doctrine of unjust enrichment. See, *e.g.*, *Provident Life & Accident Ins. Co.* v. *Waller*, 906 F.2d 985 (4th Cir. 1990) (unjust enrichment); *Collins* v. *American Cast Iron Pipe Co.*, 105 F.3d 1368 (11th Cir. 1997) (workers compensation offset). The question of the relationship between the clear language of ERISA plans and these background common law principles will continue to arise and consume plan and participant resources unless this Court resolves it in this case.

The varying obligations and the concomitant uncertainty created by the court of appeals' decision is contrary to the purposes of ERISA and ultimately may harm plan participants and beneficiaries. Because "[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans," *Curtiss-Wright Corp.*, 514 U.S. at 78, any result that increases the cost or difficulty of creating or administering an employee benefit plan may result in reduced benefits. "A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax*, 482 U.S. at 11. *Accord Shaw* v. *Delta Airlines, Inc.*, 463 U.S. 85, 105 n.25 (1983) (recognizing that "the inefficiencies of such a system presumably would be paid for by lowering benefit levels"). Review is warranted to ensure that ERISA plans, plan sponsors, and participants remain subject to "a uniform body of benefits law," *McClendon*, 498 U.S. at 142, and to eliminate the damaging and burdensome

uncertainty in plan administration caused by the court of appeals' decision.

III. THE SEVENTH CIRCUIT ERRED WHEN IT USED COMMON LAW PRINCIPLES TO OVERRIDE THE EXPRESS TERMS OF AN ERISA PLAN

The court of appeals' decision is wrong. ERISA is a comprehensive statute, and resort to the federal common law is appropriate only where ERISA or an ERISA plan leaves a gap. In this case, the court of appeals' application of federal common law "overr[o]de the explicit terms of an established ERISA benefit plan," and thus conflicted with ERISA's goals and purposes. *Singer* v. *Black & Decker Corp.*, 964 F.2d 1449, 1452 (4th Cir. 1992).

The Plan calls for full reimbursement without qualification, see *supra* at 7, and yet the Seventh Circuit applied a common law principle to frustrate the clear language of the Plan. In so doing, the court of appeals expressly invoked the undesirable public policy consequences of a plan rule denying application of the common fund doctrine. App. 8a. But, under ERISA, the plan language governs, and the alleged public policy benefits of a common law doctrine may not override the private parties' decision as embodied in the plan. ERISA *permits* plan sponsors to offer, or plan participants to bargain for, full reimbursement or partial reimbursement. See *supra* at 8-9. As this Court has many times held, under ERISA, the *private* parties define the substantive content of ERISA welfare plans. See *Alessi*, 451 U.S. at 511; cases cited *supra* at 9. Moreover, as explained above, the Seventh Circuit's refusal to enforce the Plan as written creates administrative inefficiencies and uncertainties that may, in turn, reduce benefits to plan participants. See *supra* at 18. Both consequences – the failure to abide by the private parties' determinations about the terms of the plan and the increase in the burdens and uncertainty of plan administration – directly contravene central purposes of ERISA.

In this case, the clear language of the Plan gives it a right to full reimbursement of the benefits paid to Wells. For ERISA to function as Congress intended, the plain language of the Plan's reimbursement provision must be enforced. The Court should grant certiorari to ensure that these objectives are fulfilled.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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September 12, 2000

APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
SEVENTH CIRCUIT

No. 99-2018

WAL-MART STORES, INCORPORATED ASSOCIATES' HEALTH AND WELFARE PLAN; AND ADMINISTRATIVE COMMITTEE, ADMINISTRATOR OF THE PLAN,
Plaintiffs-Appellees,

v.

DENISE WELLS,
Defendant-Appellant.

Argued Feb. 15, 2000
Decided May 17, 2000

Before POSNER, Chief Judge, and EASTERBROOK and DIANE P. WOOD, Circuit Judges.

POSNER, Chief Judge.

This is a suit by an ERISA welfare plan and its administrator (only the latter is a fiduciary and hence a proper plaintiff, ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3); *Administrative Committee v. Gauf*, 188 F.3d 767, 770 (7th Cir.1999), but we'll ignore that detail), for reimbursement of $10,982.61 paid under the plan to a participant for medical expenses that she incurred because of an automobile accident. After receiving the money from the plan, she brought a personal injury suit against the driver of the other car involved in the accident and obtained from that driver's

insurer a settlement of some $75,000, of which a third went to her lawyer. (Actually, the settlement was for claims by Wells and her husband, but as the parties make nothing of the husband's participation in the settlement, neither shall we.) The plan documents entitle the plan to reimbursement of 100 percent of any benefits paid to a participant to the extent of "any payment resulting from a judgment or settlement, or other payment or payments, made or to be made by any person or persons considered responsible for the condition giving rise to the medical expense or by their insurers." Wells claims that the plan should contribute a pro rata share of her attorneys' fees, since they were expended for the plan's benefit as well as her own. Her lawyer has a check from the insurer, payable to him as well as to Wells and her husband and to "Wal-Mart as subrogee of Denise Wells," for the entire $10,982.61 for which the plan seeks to be reimbursed. He refuses to endorse the check over to the plan. As well as seeking reimbursement, the plan asks that Wells be enjoined from continuing to violate the plan's rights by instructing or permitting her lawyer to withhold the insurer's check. It does not, however, seek interest—just the amount of the check.

We must consider whether the relief sought by the plan is equitable, because that is the only type of relief that ERISA authorizes a fiduciary to obtain. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3); *Mertens v. Hewitt Associates*, 508 U.S. 248, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993); *Health Cost Controls of Illinois, Inc. v. Washington*, 187 F.3d 703, 710 (7th Cir.1999). We can set to one side the claim for an injunction, to which—were the claim legitimate—a claim for damages could ordinarily be appended under the "clean-up" doctrine of equity and, so appended, would be classified as itself equitable, e.g., *Burns v. First National Bank*, 336 Ark. 406, 985 S.W.2d 747 (1999); *American Appliance, Inc. v. Brady*, 712 A.2d 1001 (Del.1998); see also *Medtronic, Inc. v. Intermedics, Inc.*, 725 F.2d 440, 442 (7th Cir.1984); see generally 1 Dan B. Dobbs, *Dobbs on the Law of Remedies:*

Damages—Equity—Restitution § 2.7, pp. 180-81 (2d ed.1993)—though possibly not in an ERISA case. For the Supreme Court said in *Mertens* that only typical equitable relief is available under that statute. 508 U.S. at 255-57, 113 S.Ct. 2063; see also *Reich v. Continental Casualty Co.*, 33 F.3d 754, 756 (7th Cir.1994). However that may be, a plaintiff cannot convert a claim of damages for breach of contract into an equitable claim by the facile trick of asking that the defendant be enjoined from refusing to honor its obligation to pay the plaintiff what the plaintiff is owed under the contract and appending to that request a request for payment of the amount owed. A claim for money due and owing under a contract is "quintessentially an action at law." *Hudson View II Associates v. Gooden*, 222 A.D.2d 163, 644 N.Y.S.2d 512, 516 (1996); see also *Atlas Roofing Co. v. Occupational Safety & Health Review Comm'n*, 430 U.S. 442, 459, 97 S.Ct. 1261, 51 L.Ed.2d 464 (1977).

But there is more here. Wells's lawyer is holding $10,982.61 to which the plan claims to be entitled. Wells wants the claim reduced to reflect the attorneys' fees she expended in obtaining the settlement of which the $10,982.61 is a part. But since she concedes that some (in fact the bulk) of this amount is rightfully the plan's, the lawyer's interception of the entire amount en route from the insurer to the plan is clearly wrongful. In *Health Cost Controls of Illinois, Inc. v. Washington*, *supra*, 187 F.3d at 710-11, a similar case, we held that the plan was seeking to impose on the money intercepted in transit a constructive trust—a classic form of equitable relief against someone (not necessarily a fiduciary, e.g., *In re Estate of Cohen*, 83 N.Y.2d 148, 608 N.Y.S.2d 398, 629 N.E.2d 1356, 1359 (1994); *Schwartz v. Horn*, 31 N.Y.2d 275, 338 N.Y.S.2d 613, 290 N.E.2d 816, 817-18 (1972); *Pope v. Garrett*, 147 Tex. 18, 211 S.W.2d 559, 561-62 (1948)) who is holding property that is rightfully the plaintiff's. *Clair v. Harris Trust & Savings Bank*, 190 F.3d 495, 498-99 (7th Cir.1999); *Beatty v. Guggenheim*

Exploration Co., 225 N.Y. 380, 122 N.E. 378 (1919) (Cardozo, J.). In the *Washington* case the money was being held in escrow pending the resolution of the dispute between the plan and the participant. In this case the money is being held by a lawyer, presumably also in an escrow account (a lawyer is not permitted to commingle a client's funds with his own), and the question is whether the beneficial owner is Wells, by virtue of the settlement with the tortfeasor, or the plan, by virtue of its contract with Wells.

Some cases, including our own *Administrative Committee v. Gauf*, *supra*, 188 F.3d at 770-71, seem inclined to classify all claims of reimbursement by an ERISA plan as equitable, perhaps because of ERISA's very broad preemption clause, ERISA § 514, 29 U.S.C. § 1144; Jay Conison, *Employee Benefit Plans in a Nutshell* 302, 317-19 (2d ed.1998), which might disable a plan from enforcing its rights to reimbursement if suits to enforce them were classified as legal. See also *Blue Cross & Blue Shield of Alabama v. Sanders*, 138 F.3d 1347, 1352-53 n. 5 (11th Cir.1998); *Southern Council of Industrial Workers v. Ford*, 83 F.3d 966, 969 (8th Cir.1996) (per curiam). The Ninth Circuit is at the opposite pole. See *Reynolds Metals Co. v. Ellis*, 202 F.3d 1246, 1247-49 (9th Cir.2000); *Cement Masons Health & Welfare Trust Fund v. Stone*, 197 F.3d 1003 (9th Cir.1999); *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1260-62 (9th Cir.1997). We need not consider in this case the outer bounds of ERISA's concept of equity, as a suit to impose a constructive trust nestles comfortably within them under any view. *Owens*, in contrast, was explicit in saying that the plan had *not* sought the imposition of a constructive trust. *Id.* at 1261.

So we have jurisdiction and can proceed to the merits. The language from the plan document that we quoted earlier seems clear, and clearly to favor the plan's claim. But contracts—which for most purposes ERISA plans are,

Herzberger v. Standard Ins. Co., 205 F.3d 327, 330 (7th Cir.2000); see also John H. Langbein, "The Contractarian Basis of the Law of Trusts," 105 *Yale L.J.* 625 (1995)—are enacted against a background of common-sense understandings and legal principles that the parties may not have bothered to incorporate expressly but that operate as default rules to govern in the absence of a clear expression of the parties' intent that they not govern. This principle has been applied to the interpretation of ERISA plans in a number of cases in this and other courts. See *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1297-99 (7th Cir.1993); *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 141 (8th Cir.1997); *Cagle v. Bruner*, 112 F.3d 1510, 1520-22 (11th Cir.1997) (per curiam); *Barnes v. Independent Automobile Dealers Ass'n*, 64 F.3d 1389, 1394-96 (9th Cir.1995). To read the Wal-Mart plan literally would allow the plan to free ride on the efforts of the plan participant's attorney, contrary to the equitable concept of "common fund" that governs the allocation of attorney's fees in cases in which the lawyer hired by one party creates through his efforts a fund in which others are entitled to share as well. *Boeing Co. v. Van Gemert*, 444 U.S. 472, 478, 100 S.Ct. 745, 62 L.Ed.2d 676 (1980); *Sprague v. Ticonic National Bank*, 307 U.S. 161, 166, 59 S.Ct. 777, 83 L.Ed. 1184 (1939); *Davis v. Carl Cannon Chevrolet-Olds, Inc.*, 182 F.3d 792, 795 (11th Cir.1999); 1 Dobbs, *supra*, § 3.10(2), pp. 393-98; John P. Dawson, "Lawyers and Involuntary Clients: Attorney Fees From Funds," 87 *Harv. L. Rev.* 1597 (1974).

It would also gratuitously deter the exercise of the tort rights of plan participants. For one can easily imagine a case in which, under the plan's interpretation, the participant (or nonparticipant beneficiary, such as a spouse or child) would lose part of her plan benefits simply by virtue of having exercised her right to bring a tort suit against a third party. Suppose Wells had obtained a settlement of $12,000 of which her lawyer got $4,000 pursuant to a standard contingent-fee

contract, leaving her with $8,000. Since the settlement would exceed $10,982.61, the plan under its theory would be entitled to that entire amount, leaving her worse off by $2,982.61 than she would have been had she not sued. This would be true even if she had sought no medical benefits, or any other benefits available under the plan, in that suit—it might have been a suit purely for damage to her car. This prospect might well deter a suit likely to result in a judgment or settlement not much larger than the benefits available under the plan—and in that event the language on which the plan relies would produce undercompensation for harms that were unrelated to the type of harm to which the benefits pertain. Wells would have been surprised to have been told when she signed onto this plan that as a result of it she might not be able to obtain compensation for tortiously inflicted property damage. The plan itself might well be worse off in the long run, as it would have to incur attorneys' fees in order to enforce its right of subrogation. See *Blackburn v. Sundstrand Corp.*, 115 F.3d 493, 496 (7th Cir.1997).

The plan documents neither advert to the anomaly just discussed nor expressly repudiate common-fund principles, and so they do not alter the background understanding of the allocation of attorneys' fees that is embodied in those principles. We interpolate those principles to avoid wreaking unintended consequences. *United McGill Corp. v. Stinnett*, 154 F.3d 168, 172-73 (4th Cir.1998), and *Bollman Hat Co. v. Root*, 112 F.3d 113, 116-18 (3d Cir.1997), are only superficially in conflict with this result. They refuse to invalidate a plan provision interpreted to bar the application of common-fund principles; we pose the issue as one not of validity but of sound application of principles of contract interpretation. More problematic is *Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938 (5th Cir. 1998) (per curiam), which upheld a literal reading of identical language—but did so as a matter of deference to the interpretation by the plan's administrator.

That's a critical qualification. In cases in which the plan documents give the plan's administrator discretion to interpret the plans, our review is deferential. E.g., *Mers v. Marriott International Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998); *Fuller v. CBT Corp.*, 905 F.2d 1055, 1058 (7th Cir.1990). But the presumption is against deference, *Herzberger v. Standard Ins. Co.*, *supra*, and has not been rebutted. For there is no reference to discretion in the part of the plan documents that deals with the plan's right to reimbursement—only in the part that deals with benefits determinations. Determinations of benefits, determinations that supervene on interpretation of key terms such as "disability," invite the exercise of discretion, being inescapably particularistic and fact-bound; determinations of issues related solely to the financial aspects of the plan do not.

An amendment in 1996 to the plan that was in force when Wells was injured and sought and received benefits *explicitly* refuses to pick up any part of the plan participant's attorneys' fees, as in *Health Cost Controls v. Isbell*, 139 F.3d 1070 (6th Cir.1997), and *Ryan v. Federal Express Corp.*, 78 F.3d 123, 124, 127 (3d Cir.1996). The plan argues that the amendment is applicable to the claim of reimbursement because the claim was made in 1997, after the amendment took effect. This is an astonishing argument, implying as it does that the amending power can be used to force plan participants and beneficiaries to return benefits already received and spent. The logic of the argument is that if the plan were amended to abolish some class of benefits (say, reimbursement for the cost of treating mental disorders), the recipients could be forced to disgorge them even if they had received the benefits many years earlier. The argument was rejected in the very case that the plan mistakenly cites in support of it. *Member Services Life Ins. Co. v. American National Bank & Trust Co.*, 130 F.3d 950, 957-58 (10th Cir.1997).

Because the 1996 amendment is inapplicable to this case, we need not consider whether state "common fund" law, see Ind.Code. §§ 34-53-1-2, 34-51-2-19, is applicable at all, because either in terms, Ind.Code § 34-53-1-2, or as a matter of interpretation, *Allstate Ins. Co. v. Smith*, 656 N.E.2d 1156, 1158 (Ind.App.1995); *Standard Mutual Ins. Co. v. Pleasants*, 627 N.E.2d 1327, 1330 (Ind.App.1994), it is applicable only to insurers, and an ERISA plan is not deemed to be (and the Wal-Mart plan is not contended to be) an insurer. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B); *Stillmunkes v. Hy-Vee Employee Benefit Plan & Trust*, 127 F.3d 767, 770 (8th Cir.1997). We likewise need not consider whether, if the state's common fund law is otherwise applicable, it is preempted by ERISA. Although, as explained in *Blackburn v. Sundstrand Corp.*, *supra*, 115 F.3d at 496, state laws of general applicability that affect ERISA plans no differently from similar economic activity are not preempted by ERISA, our decision in *Administrative Committee v. Gauf*, *supra*, 188 F.3d at 771, holds that when (unlike the situation in *Blackburn*) an ERISA plan is the plaintiff in a suit claiming reimbursement, its claim arises under and is governed by ERISA, or by federal common law created under the authority of ERISA. Whether *Gauf* and *Blackburn* can coexist is thus another issue we needn't try to resolve today; nor whether, if the state's common fund law is not preempted and is fully applicable, it can nevertheless be overridden by an express contractual provision, as intimated in *Sell v. United Farm Bureau Family Life Ins. Co.*, 647 N.E.2d 1129, 1133 (Ind.App.1995); nor whether if it is preempted it is preempted in favor of a similar federal common law doctrine, as implied by *McIntosh v. Pacific Holding Co.*, 120 F.3d 911 (8th Cir.1997), and *Waller v. Hormel Foods Corp.*, *supra*, 120 F.3d at 141, but rejected in *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 278-79 (1st Cir.2000), and if so whether that doctrine, too, can be overridden by an express provision in the plan, as implied by *United McGill Corp. v.*

Stinnett, supra, 154 F.3d at 172-73; *Health Cost Controls v. Isbell, supra*; *Bollman Hat Co. v. Root, supra*, 112 F.3d at 116-18, and *Ryan v. Federal Express Corp., supra*, 78 F.3d at 127.

Wells seeks not only a sharing of the attorneys' fees with the plan, to which she is entitled, but also a sharing of the reduction of her claim in the settlement by 25 percent to reflect her comparative fault. We are at a loss to understand how that reduction, unlike the expense of the lawyer who obtained the settlement, could be thought to have conferred a benefit on the plan for which it should contribute a part of the cost under common-fund principles. And while Indiana law, were it applicable, might provide the relief she is seeking, see Ind.Code § 34-51-2-19, she does not invoke that or any other provision of Indiana law, and so has waived the argument.

REVERSED.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION

No. 2:97-CV-422-RL-2

WAL-MART STORES, INC.,
ASSOCIATES' HEALTH AND WELFARE PLAN,
Plaintiff,

vs.

DENISE WELLS,
Defendant.

ORDER

This matter is before the Court on Plaintiff's Motion for Summary Judgment, filed on July 1, 1998, and Defendant's Motion for Summary Judgment, filed on July 1, 1998. For the reasons set forth below, Plaintiff's motion is GRANTED and Defendant's motion is DENIED. The Clerk is ORDERED to DISMISS this case with prejudice.

BACKGROUND

Denise Wells ("Wells") was injured in an automobile accident in 1993. Because Wells was a participant in Wal-Mart Stores, Inc. Associates' Health and Welfare Plan ("the Plan"), the Plan paid $10,982.61 for some of her medical expenses pursuant to the 1993 Summary Plan Description ("1993 SPD") and the 1993 Wal-Mart Associates' Health Plan Document ("1993 Health Plan Document") (together "1993 Plan documents"). On her own, Wells filed a personal injury suit against a third party and settled the claim for

$73,700. The mediation settlement agreement found Wells 25% at fault.

Wells notified the Plan that she had settled her suit, and requested that the Plan reduce its reimbursement lien by one-third for her attorney's fees. The Plan's Administrative Committee reviewed her request, and determined that the reimbursement provisions of the Plan's 1996 Summary Plan Description ("1996 SPD") provided for 100% reimbursement, without reduction for attorney's fees. When Wells refused the Plan's demand, the Plan filed suit against her based on 29 U.S.C. sections 1132(a)(3) and (e)(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan requests that the Court compel Wells to reimburse the Plan for 100% of the $10,982.61 it paid for her medical expenses. Both parties have filed motions for summary judgment.

In its November 23, 1998 Order, the Court found that the 1993 Plan documents, rather than the 1996 SPD, apply in this case. Further, the Court determined that Indiana Code section 34-4-33-12, Indiana's comparative fault statute, and the Indiana common fund doctrine do not apply in this case. In order to rule on the summary judgment motions, the Court requested that the parties submit briefs on three issues: (1) the creation of federal common law in this case; (2) the discretion afforded the Administrative Committee under the 1993 Plan documents; and (3) whether the Administrative Committee's decision was arbitrary and capricious. The Court will address each of these issues, though in a somewhat altered sequence.

DISCUSSION

The standards generally governing summary judgment motions are familiar. Pursuant to Rule 56(c) of the Federal Rules of Civil Procedure, summary judgment is proper only if it is demonstrated that there is no genuine issue as to any

material fact and that the moving party is entitled to a judgment as a matter of law. *See Nebraska v. Wyoming*, 507 U.S. 584, 590 (1993); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986). In other words, the record must reveal that no reasonable jury could find for the nonmovant. *Karazanos v. Navistar Int'l Transp. Corp.*, 948 F.2d 332, 335 (7th Cir. 1991); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250 (1986). In deciding a motion for summary judgment, a court must read all facts in the light most favorable to the nonmovant. *Anderson*, 477 U.S. at 255; *Nucor Corp. v. Aceros Y Maquilas De Occidente*, 28 F.3d 572, 583 (7th Cir. 1994)

The burden is on the movant to identify those portions of "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits," if any, which it believes demonstrate an absence of a genuine issue of material fact. *Celotex*, 477 U.S. at 323. Once the moving party has met this burden, the nonmoving party may not rest upon mere allegations but "must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56 (e); *Becker v. Tanenbaum-Hill Assoc., Inc.*, 914 F.2d 107, 110 (7th Cir. 1990); *Schroeder v. Lufthansa German Airlines*, 875 F.2d 613, 620 (7th Cir. 1989). "Whether a fact is material depends on the substantive law underlying a particular claim and 'only disputes over facts that *might affect the outcome* of the suit under governing law will properly preclude the entry of summary judgment.'" *Walter v. Fiorenzo*, 840 F.2d 427, 434 (7th Cir. 1988) (citing *Anderson*, 477 U.S. at 248).

"[A] party who bears the burden of proof on a particular issue may not rest on its pleadings, but must affirmatively demonstrate, by specific factual allegations, that there is a *genuine* issue of material fact which requires trial." *Beard v. Whitley County REMC*, 840 F.2d 405, 410 (7th Cir. 1988); *see also Hickey v. A.E. Staley Mfg.*, 995 F.2d 1385, 1391 (7th

Cir. 1993). Therefore, if a party fails to establish the existence of an essential element of its case on which it bears the burden of proof at trial, summary judgment will be appropriate. In this situation, there can be "'no genuine issue as to any material fact', since a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial." *Celotex*, 477 U.S. at 323.

The Administrative Committee's Discretion

In cases where an ERISA plan gives an administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan, the courts may not review the administrator's decisions on a *de novo* basis. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). Rather, the standard is whether the plan administrator abused his or her discretion to arrive at a decision that was "arbitrary and capricious." *Id.* To determine whether the Administrative Committee was exercising discretionary powers, the Court must look to the terms of the agreement. *Sanders v. Scheideler*, 816 F. Supp. 1338, 1342 (W.D. Wis. 1993). The interpretation of an agreement governed by ERISA is a matter of federal law. *Diehl v. Twin Disk, Inc.*, 102 F.3d 301, 305 (7th Cir. 1996). The relevant principles of contract interpretation are a body of federal common law tailored to the policies of ERISA. *Santaella v. Metropolitan Life Ins. Co.*, 123 F.3d 456, 461 (7th Cir. 1997); *Mathews v. Sears Pension Plan*, 144 F.3d 461, 465 (7th Cir.), *cert. denied*, 119 S. Ct. 618 (1998). When interpreting an agreement, the Court must consider related documents together and should give the terms in the agreement their ordinary and popular meaning as would a person of average intelligence and experience. *Diehl*, 102 F.3d at 305; *Central States, Southeast and Southwest Areas Pension Fund v. Kroger Co.*, 73 F.3d 727, 731 (7th Cir. 1996).

The Plan claims that both 1993 Plan documents contain language giving the Administrative Committee discretion to act. The 1993 Health Plan states:

> [t]he Plan expressly gives the Administrative Committee *discretionary authority to resolve all questions concerning the administration, interpretation or application of the Plan*, including, without limitation, discretionary authority to determine eligibility for benefits or to construe the terms of the Plan in conducting the review of the appeal. When making its initial determination pursuant to the claim denial and appeals section of this plan document, the Plan shall also have such discretionary authority.

(Def.'s Ex. C, pp. D52-53) (emphasis added). Wells insists that a reasonable interpretation of these documents leads a person to conclude that the Administrative Committee's discretion is limited only to denial of claims and appeals because this language falls under a provision entitled, "Claim Denial and Appeal", within the "General Provisions" section. She notes that no such language is found under the General Provision entitled, "Rights to Reduction and Reimbursement". Wells also points to a parenthetical in the 1993 SPD's provision entitled "Review of Claim Denial" which mentions that the Administrative Committee "has been expressly given, by the Plan, discretionary authority to resolve all questions concerning the administration, interpretation, or application of the Plan." (Def. Ex. D, p. D14) . She claims that the burial of this sentence in the paragraph demonstrates the Plan's intent to limit the Administrative Committee's discretion to the review of claim denial.

Walker v. Wal-Mart Stores, Inc. considered a provision identical to the provision quoted above from the 1993 Health Plan document. 159 F.3d 938, 939 (5th Cir. 1998). Without

considering the provision's placement in the plan document, the court found it "clearly vested the Administrative Committee with the discretionary authority to interpret the terms of the Plan." *Id.* As a result, the court found that the proper standard of review of the Administrative Committee's decision was for abuse of discretion. *Id.* at 940. This Court agrees. Both documents clearly state that the Administrative Committee has discretionary authority to resolve *all* questions concerning the administration, interpretation, and application of the Plan. *See Fought v. Evans Prods. Co. Racine Pension Plan Agreement*, 966 F.2d 304, 305-06 (7th Cir. 1992) (finding the language authorizing the fiduciary "to construe the Plan" grants deferential review) *and Saracco v. Local Union 786 Bldg. Material Pension Fund*, 942 F.2d 1213, 1214 (7th Cir. 1991) (requiring deference where trust gave trustees discretion to determine all questions arising in the administration, interpretation, and application of the plan). Wells offers no authority to support her argument based on the location of the provisions in the 1993 Plan documents. Thus, the Court finds that the 1993 Plan documents afforded the Administrative Committee discretionary authority.

The Administrative Committee's Decision

When an ERISA plan gives administrators discretionary authority, the appropriate standard of review is whether the decision was arbitrary and capricious. *Allison v. Dugan*, 951 F.2d 828, 832 (7th Cir. 1992). "A decision is arbitrary and capricious when the decision-maker had relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence . . ., or is so implausible that it could not be ascribed to a difference in view or the product of expertise." *Filipowicz v. American Stores Benefit Plans Committee*, 56 F.3d 807, 813 (7th Cir. 1995) (citations omitted). Under the

arbitrary and capricious standard, an administrator's decision will be upheld as long as "it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome." *Exbom v. Central States, Southeast and Southwest Areas Health and Welfare Fund*, 900 F.2d 1138, 1142 (7th Cir. 1990) (quoting *Pokratz v. Jones Dairy Farm*, 771 F.2d 206, 209 (7th Cir. 1985)). It is not the Court's function to decide whether it would reach the same conclusion as the Plan or even rely on the same authority. *Mers v. Marriott Intern. Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir.), *cert. denied*, 119 S.Ct. 372 (1998). If there is a " 'rational connection' between the issue to be decided, the evidence in the case, the text under consideration, and the conclusions reached, then the [administrator's] decision is final." *Saracco*, 942 F.2d at 1215. To be overturned, the administrator must have abused its discretion; it was "not just clearly incorrect but downright unreasonable." *Fuller v. CBT Corp.*, 905 F.2d 1055, 1058 (7th Cir. 1990).

In order to assess whether the Plan's decision to require 100% reimbursement was arbitrary and capricious, the Court looks to the contract terms of the agreement. *See Filipowicz*, 56 F.3d at 812. The Court must decide whether the agreement is ambiguous, and if it is, whether, after consideration of extrinsic evidence, there are triable issues of fact. *Hickey v. A.E. Staley Mfg.*, 995 F.2d 1385, 1389 (7th Cir. 1993) (noting that the court may consider extrinsic evidence when interpreting an agreement only if the agreement is ambiguous). Because the Court's review is deferential, if the agreement is ambiguous, the Court will accept any reasonable interpretation of the 1993 Plan documents' terms by the Administrative Committee. *See Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1149 (7th Cir. 1998); *Morton v. Smith*, 91 F.3d 867, 871 n.1 (7th Cir. 1996) ("When the administrators of a plan have discretionary authority to

construe the plan, they have discretion to determine the intended meaning of the plan's terms.").

The 1993 Health Plan document states:

> The Plan shall have the right to . . . recover benefits previously paid by the Plan to the extent of any and all of the following:
>
> A. any payment resulting from a judgment or settlement . . . made or to be made by any person or persons considered responsible for the condition given rise to the medical expense or by their insurers, regardless of whether the payment is designated as payment for such damages including, but not limited to, pain and/or suffering, loss of income, medical benefits or any other specified damages; or any other damages made or to be made by any person . . .

(Def. Ex. C., p. D48). Similarly, the 1993 SPD states:

> The Plan has the right to . . . recover benefits previously paid by the Plan to the extent that medical expenses may be payable in any of the following:
>
> A. Any judgment, settlement, or any payment, made or to be made by a person considered responsible for the condition giving rise to the medical expense or by their insurers.

(Def. Ex. D, p. D94). The terms of the 1993 Plan documents do not specifically state that the Plan is entitled to 100% reimbursement. Wells argues that the 1993 Plan documents' terms are ambiguous and therefore, the Court should adopt and apply the "make whole" rule of interpretation. *See Cutting v. Jerome Foods, Inc.*, 993 F.3d 1293, 1298 (7th Cir. 1993). The "make whole" rule would prevent the Plan from enforcing any subrogation rights until Wells has been fully compensated for all losses. *See Cagle v. Flick*, 3 F. Supp. 2d

982, 987 (N.D. Ind. 1998). Wells claims that she should only have to reimburse the Plan to the extent she recovered from the third party, that is, 25% less than full reimbursement due to comparative fault, and one-third less for attorney's fees and costs.

The "make whole" rule does not apply here. In *Cutting v. Jerome Foods, Inc.*, the Seventh Circuit held that where a plan did not specifically accept or reject the "make whole" rule, and the administrator had discretionary authority to interpret ambiguous language in the plan, it was not arbitrary for the administrator to conclude that the plan did not incorporate the "make whole" rule. 993 F.2d at 1298-99; *Cagle*, 3 F. Supp. 2d at 987. Wells admits that the 1993 Plan documents do not address the "make whole" rule. (Def. Supp. Brief, p. 8). Because the Administrative Committee had the discretion to interpret the 1993 Plan documents, the Court finds that it was not arbitrary and capricious for the Administrative Committee to determine that the 1993 Plan documents did not include the "make whole" rule. *See Kaszula v. Parker*, No. 96C6903, 1998 WL 142422, *3 (N.D. Ill. March 26, 1998).

In *Walker*, the Fifth Circuit considered reimbursement terms identical to the 1993 health plan document. 159 F.3d at 940. Noting that Congress intended ERISA plans to be "written in a manner calculated to be understood by the average plan participant," the court found the plan's language to be unambiguous. *Id.* "[T]he 'any and all' language plainly means the first dollar of recovery (any) and 100% recovery (all) of the funds received by the plaintiff in the settlement, up to full amount of the benefits paid." *Id.*; *see Cagle*, 3 F. Supp. 2d at 987 (finding language that a fund was subrogated to "all rights of recovery . . . against any third party or any insurer . . . to the extent of any and all payments made or to be made by the Plan" was reasonably interpreted as allowing full subrogation under the arbitrary and capricious standard). The

administrator's interpretation of the plan was found to be correct. *Walker*, 159 F.3d at 940-41. In this case, the Administrative Committee was granted discretion to interpret the 1993 Plan documents. The Committee's decision that the Plan was entitled to full subrogation, rather than applying the "make whole" rule, was a reasonable interpretation of the 1993 Plan documents.

Federal Common Law

Federal courts may fashion federal common law rules to govern ERISA suits when ERISA is silent on an issue. *Fox Valley & Vicinity Construction Workers Pension Fund v. Brown*, 897 F.2d 275, 281 (7th Cir. 1990); *Firestone*, 489 U.S. at 108. Although the court may create such federal common law as it deems necessary to carry out the purposes of ERISA where ERISA is silent, that creative license is not to be exercised without discretion. *Trustmark Life Ins. Co. v. University of Chicago Hospitals*, No. 94C4692, 1995 WL 75367, *5 (N.D. Ill. Feb. 2, 1995); *Powers v. United States Postal Service*, 671 F.2d 1041, 1043 (7th Cir. 1982). The court should not employ federal common law "when the plain language of the ERISA plan invests the plan administrator with discretion to interpret the plan, and the administrator has not interpreted the plan in an arbitrary and capricious manner." *Cagle*, 3 F. Supp. 2d at 988 (citing *Cutting*, 993 F.2d at 1298-99).

Wells contends that because the 1993 Plan documents are ambiguous regarding attorney's fees, she should be allowed to reduce the amount of reimbursement by one-third. The "common fund" doctrine allows "a party who creates, preserves, or increases the value of a fund in which others have an ownership interest to be reimbursed from that fund for litigation expenses incurred, including counsel fees." *Kaszula*, 1998 WL 142422 at *4. ERISA is silent as to the "common fund" doctrine, and some courts have found it

"appropriate to apply the common-fund doctrine as federal common law." *Id.*; *see Carpenter v. Modern Drop Forge Co.*, 919 F. Supp. 1198, 1206 (N.D. Ind. 1995); *Dugan v. Nickla*, 763 F. Supp. 981 (N.D. Ill. 1991); *cf. Cagle*, 3 F. Supp. 2d at 987 (refusing to apply the common fund doctrine).

Considering the same language in the 1993 Health Plan document, the Fifth Circuit found that "the unambiguous language [did] not include a reduction of the subrogation lien for payment of attorneys fees and costs." *Walker*, 159 F.3d at 940. "[T]he fact that the provisions do not specifically mention attorneys' fees or set out detailed distribution procedures, does not constitute silence or ambiguity on behalf of the Plan." *Id.*; *see United McGill Corp. v. Stinnett*, 154 F.3d 168, 173 (4th Cir. 1998) (refusing to reduce an award for attorney's fees where the Plan's language did not qualify the right to reimbursement by reference to recovery costs because "applying federal common law to override the Plan's reimbursement provision would contravene, rather than effectuate, the underlying purposes of ERISA."). The *Walker* court refused to apply the "common fund" doctrine to the ERISA plan.

No provision in the 1993 Plan documents specifically provides that attorney's fees and costs may be deducted from a subrogation lien. Under *Walker*, the "common fund" doctrine should not apply because the 1993 Plan documents are unambiguous, that is, they do not provide for such reduction. The Seventh Circuit has not yet specifically addressed the relation between a plan's ambiguity and the "common fund" doctrine. *But see Blackburn v. Becker*, 933 F. Supp. 724, 729 (N.D. Ill. 1996) (finding it lacked authority to provide for attorney fees apportionment where the Plan unambiguously provided for full reimbursement), *vacated on other grounds by Blackburn v. Sunstrand*, 115 F.3d 493 (7th Cir.), *cert. denied*, 118 S. Ct. 562 (1997). This circuit's

district courts have a history of applying the "common fund" doctrine in similar cases. *See, e.g., Kaszula*, 1998 WL 142422 at *4; *Carpenter*, 919 F. Supp. at 1205-06; *Dugan*, 763 F. Supp. at 984-85; *Cutting v. Jerome Foods, Inc.*, 820 F. Supp. 1146, 1155 (W.D. Wis. 1991). As a result, the Court hesitates to rest its ruling on this basis.

In *Dugan v. Nickla*, a fund filed a subrogation action for reimbursement of medical payments that the defendant had recovered in a state court medical malpractice action. 763 F. Supp. at 984. In a single paragraph, the Northern District of Illinois found that if the defendant had not engaged an attorney and pursued his malpractice case, the fund would not have recovered any of the cost of the defendant's medical benefits. *Id.* The court did not refer to or rely on any plan provision. Rather, because the fund benefitted from the defendant's pursuit of his case, the court ordered a one-third reduction of the fund's share of the verdict for attorney's fees. *Id.*; *cf. Blackburn*, 933 F. Supp. at 729 (refusing to provide for attorney fees apportionment where the plan provided for full reimbursement).

Similarly, in *Cutting v. Jerome Foods, Inc.*, the plaintiffs sued an ERISA plan in order to avoid application of the plan's subrogation clause to their recovery in a personal injury suit against a third party. 820 F. Supp. at 1146. Among other issues, the Western District of Wisconsin considered a reduction in the plan's award for plaintiffs' attorney's fees. *Id.* at 1155. The court found that the plan's reimbursement clause did not include amounts attributable to attorneys' fees incurred by participants who pursued their claims against third parties. *Id.* The court reduced the amount payable to the plan under its subrogation clause by an amount proportionate to the plaintiffs' attorney's fees, noting that if plaintiffs had not engaged an attorney and pursued their claim, the plan would not have recovered any of the benefits paid. *Id.* at 1156 (citing *Dugan*, 763 F. Supp. at 984-85). On appeal, the

Seventh Circuit noted that the plan afforded the administrator discretion to interpret the plan, but did not visit the issue of apportioning attorney's fees and costs. *Cutting*, 993 F.2d 1293; *cf. Cagle*, 3 F. Supp. 2d at 988 (holding that where an ERISA plan invests the administrator with discretion to interpret the plan, and the administrator has not interpreted it in an arbitrary and capricious manner, the "common fund" doctrine does not apply as federal common law). While it is not certain whether the Seventh Circuit deliberately ignored the conflict between the fairness concerns raised by the district court and the deference to be afforded an administrator in interpreting a plan, it gives the Court pause.

In *Carpenter v. Modern Drop Forge Co.*, this Court allowed plaintiffs to reduce the sum they owed their insurer under a subrogation clause in an ERISA plan by a proportionate amount of the attorney's fees they incurred in resolving an underlying claim. 919 F. Supp. at 1204. It is assumed that the plan did not address a reduction for such attorney fees, as there was no mention of the issue. The Court discussed *Dugan*, as well as *Cutting*, in depth before deciding to allow reduction for attorney's fees. *Id.* at 1203-06. Without deciding whether the administrator was afforded the discretion to interpret the plan, the Court noted that *Dugan* and *Cutting* "grounded their opinions on the inherent and equitable authority of the court to determine what is fair." *Id.* at 1206; *see also Kaszula*, 1998 WL 142422 at *4 (applying the "common fund" doctrine as federal common law because the plan ought not "be a free ride on the journey to collect for a tort").

Recently, in *Cagle v. Flick*, this Court declined to employ the "common fund" doctrine where the plain language of an ERISA plan invested the plan administrator with the discretion to interpret the plan, and the administrator had not done so in an arbitrary and capricious manner. 3 F. Supp. 2d at 988; *Health and Welfare Plan for Employees of REM, Inc.*

v. Ridler, 942 F. Supp. 431, 434 (D. Minn. 1996) ("the task of the Court is to interpret the Plan—or more precisely, defer here to the reasonable interpretation of the Plan's Administrator. . . . The interpretive tool of a growing body of federal common law applicable to ERISA actions is not a license to rewrite the Plan to the Court's taste."), *aff'd*, 124 F.3d 207 (8th Cir. 1997). The Court noted that where "the administrator has not interpreted the plan provisions in an 'arbitrary and capricious' manner, the administrator's interpretation controls and federal common law will not apply." *Cagle*, 3 F. Supp. 2d at 987-88. The Court distinguished its decision from *Carpenter*, claiming that the plan in *Carpenter* did not afford the administrator discretion to interpret the plan. *Cagle*, 3 F. Supp. 2d at 988.

Having seriously considered these cases, the Court is reminded that the Administrative Committee was afforded the discretion to interpret the terms of the 1993 Plan documents. As a result, the Court must examine the Administrative Committee's decisions based on the arbitrary and capricious standard. This does not mean that the Court would come to the same conclusion as the Administrative Committee. *Mers*, 144 F.3d at 1021. Rather, the Court must find that its decision was "not just clearly incorrect, but downright unreasonable." *Fuller*, 905 F.2d at 1058. The Court has reviewed the 1993 Plan documents, and finds that the Administrative Committee's decision not to reduce the amount of reimbursement by one-third was not arbitrary and capricious. As such, the Administrative Committee's interpretation controls, and federal common law will not apply. *See Cagle*, 3 F. Supp. 2d at 988; *Ridler*, 942 F. Supp. at 434.

Wells also asks that the Court adopt as federal common law a principle similar to Indiana Code section 34-4-33-12. In its order dated November 23, 1998, the Court denied Wells' request to apply section 34-4-33-12 to this case. This Court has refused to adopt section 34-4-33-12 as federal common

law noting that "the interest in uniformity dictates that this court resist any temptation to apply state law as federal common law." *Carpenter*, 919 F. Supp. at 1202-03; *Murzyn v. Amoco Corp.*, 925 F. Supp. 594 (N.D. Ind. 1995). Wells offers no authority that would induce the Court to revisit this aspect of its decision in *Carpenter*. Therefore, the Court will not apply the principles of section 34-4-33-12 as federal common law.

CONCLUSION

For the reasons set forth above, the Court GRANTS Plaintiff's Motion for Summary Judgment, and DENIES Plaintiff' [sic] Motion for Summary Judgment.

ENTER: 3/26/99

/s/ RUDY LOZANO
Rudy Lozano, Judge
United States District Court

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 99-2018

WAL-MART STORES, INCORPORATED ASSOCIATES' HEALTH AND WELFARE PLAN AND ADMINISTRATIVE COMMITTEE, AS THE ADMINISTRATOR OF THE WAL-MART STORES, INCORPORATED ASSOCIATES' HEALTH AND WELFARE PLAN,
Plaintiffs-Appellees,

v.

DENISE WELLS,
Defendant-Appellant.

Decided June 14, 2000

NOTICE: DECISION WITHOUT PUBLISHED OPINION

Before Hon. Richard A. Posner, Chief Circuit Judge, Hon. Frank H. Easterbrook, Circuit Judge, Hon. Diane P. Wood, Circuit Judge.

ORDER

On May 31, 2000, plaintiffs-appellees filed a petition for rehearing and petition for rehearing *en banc*. All the judges on the original panel have voted to deny the petition, and none of the active judges has requested a vote on the petition for rehearing *en banc*. The petition is therefore DENIED.

APPENDIX D

WAL-MART ASSOCIATES' HEALTH PLAN DOCUMENT

(Excerpts)

INTRODUCTION

Name of the Plan	The name of this PLAN is the Wal-Mart ASSOCIATES' Group Health Plan. It shall hereinafter be referred to as the PLAN.
Intent of the Plan Document	The intent of this PLAN document is to clearly define the health benefits provided for the PARTICIPANTS in this PLAN. It will describe each aspect of these benefits and the eligibility requirements for PARTICIPANTS.
Outline of the Plan Document	This PLAN document is structured as follows:

Section I	General Information
Section II	Summary Schedule of Benefits
Section III	Glossary
Section IV	Major Medical Benefits
Section V	Limitations & Exclusions
Section VI	Medical Billing-Self-Audit
Section VII	Medical Case Management
Section VIII	General Provisions

Eligibility	Those individuals meeting the PARTICIPANT definition on page 16.

SECTION I—GENERAL INFORMATION

INTRODUCTION	Section I of this PLAN document explains the general concepts of the PLAN relating to funding, contribution levels of the COMPANY and ASSOCIATE, composition of the PLAN and intent of the PLAN. There is a glossary in Section III of this document. All defined terms used throughout the document appear in CAPITAL letters.
Funding of the Plan	Funding of the PLAN shall be through the Plan contributions by the COMPANY and ASSOCIATES to the Wal-Mart Group Health and Welfare Trust.
Contributions to the Plan	Contribution levels are shared by the PLAN ASSOCIATES and the COMPANY, and will be modified as needed, based on the decisions by the Trustees. Contributions are subject to the administrative guidelines.
Composition of the Plan	This PLAN is comprehensive Major Medical Benefits.
Effective Date of Plan	The EFFECTIVE DATE of this PLAN Document is January 1, 1993. This document supersedes all previous documents unless charges for covered expenses were incurred prior to January 1, 1993.

Right to Reductions and Reimbursement; Enforcement of Subrogation Rights

The PLAN shall have the right to reduce benefits otherwise payable by the PLAN or recover benefits previously paid by the PLAN to the extent of any and all of the following:

A. Any payment resulting from a judgment or settlement, or other payment or payments, made or to be made by any person or persons considered responsible for the condition giving rise to the medical expense or by their insurers, regardless of whether the payment is designated as payment for such damages including, but not limited, to pain and/or suffering, loss of income, medical benefits or any other specified damages; or any other damages made or to be made by any person; or

B. Automobile or recreational vehicle insurance payments or benefits (including but not limited to uninsured motorist coverage) to which PARTICIPANT is entitled regardless of whether the payment or benefit designated as a payment or benefit for such damages including, but not limited to, pain and/or suffering, loss of income, medical benefits or any other specified damage; or

C. Business and homeowners medical liability insurance coverage or payments, regardless of whether the payment or benefit is designated as a

coverage or payment for such damages including, but not limited to, pain and/or suffering, loss of income, medical benefits or any other specified damage.

Additionally, the PLAN is hereby given the right to file suit, on behalf of the PARTICIPANT against the person, firm or corporation deemed responsible for the condition giving rise to the medical expense or damages, to recover the benefits paid or due to be paid by the PLAN.

To facilitate the PLAN'S enforcement of its rights of recovery, reimbursement and subrogation as set forth herein, the PARTICIPANT must, at the PLAN'S request, take any action, give information and assistance, and execute documents so required by the PLAN, at its discretion. If a PARTICIPANT fails to comply, the PLAN may withhold benefits, services, payments or credits due under this PLAN document. The PARTICIPANT or anyone on his or her behalf may not do anything that might prejudice or interfere with the recovery, subrogation, or reimbursement rights of the PLAN. If the PARTICIPANT prejudices or interferes with the recovery rights of the PLAN, the PLAN may make recovery from the PARTICIPANT or from the ASSOCIATE of whom he or she is an ELIGIBLE DEPENDENT to the extent of benefits or may withhold benefits otherwise.

All benefits paid or provided by the PLAN to, or on behalf of, any PARTICIPANT shall, by agreement of the parties, be considered as advance payments of Worker's Compensation benefits or of benefits from the Social Security Administration, Veterans Administration, State and Local social services agencies, etc. In the event the PARTICIPANT is later awarded or paid Worker's Compensation benefits of any kind or description under any applicable law or is awarded or paid benefits from the Social Security Administration, Veterans Administration, State and Local social services agencies, etc., then the PLAN shall have the right to be, and shall be, reimbursed the amount of all benefits paid or provided by the PLAN to or on behalf of the PARTICIPANT.

Claim Denial and Appeal

The PLAN will, within a reasonable length of time, make the initial determination as to the rights of any PARTICIPANT to receive any benefits from this PLAN. Any denial of or decision to pend a PARTICIPANT'S claim will be set forth in writing, stating the reason for such decision. If the claim is denied or pended because the PLAN needs more information to make a decision, the PLAN will advise the PARTICIPANT, or medical supplier, or appropriate party, of the specific information needed. If a claim is denied or pended, or if the PARTICIPANT disagrees with the

PLAN'S determination of the amount of benefits paid or to be paid or some other decision, the PARTICIPANT (or sponsor) may file an appeal with the ADMINISTRATIVE COMMITTEE in care of the PLAN. Any claim appeal filed by the PARTICIPANT must be presented in writing, and received no later than 90 days after the PARTICIPANT'S receipt of the written denial or other decision that is the subject of the appeal. The ADMINISTRATIVE COMMITTEE, in consultation with the ADMINISTRATOR and the MEDICAL ADVISORY COUNCIL, if necessary, will conduct the review, decide on the appeal and notify the PARTICIPANT within a reasonable length of time of the appeal's filing. The decision on review of the appeal will include specific reasons for the decision.

The PLAN herein expressly gives the ADMINISTRATIVE COMMITTEE discretionary authority to resolve all questions concerning the administration, interpretation or application of the PLAN, including, without limitation, discretionary authority to determine eligibility for benefits or to construe the terms of the PLAN in conducting the review of the appeal. When making its initial determination pursuant to the claim denial and appeals section of this plan document, the PLAN shall also have [. . .]

[. . .] such discretionary authority.

In the event the requested information necessary to review the appeal has not been furnished within a reasonable length of time, the claims shall be deemed denied on review.

No action at law or in equity shall be brought to recover under this PLAN document until the appeal rights herein provided have been exercised and the PLAN benefits requested in such appeal have been denied in whole or in part. In no event shall any action be brought to recover under this PLAN document after the latter of two years from the filing of the claim or 45 days from the decision on the appeal.

The PLAN'S agent for service of legal process is:

PLAN ADMINISTRATOR
Wal-Mart Associates' Health &
Welfare Trust
702 S.W. 8th Street
Bentonville, AR 72712